DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/23/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445275	A. BUILDING 01 - MAIN BUILDING 01 B. WING	03/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF JEFFERSON CITY	336 WEST OLD ANDREW JOHNSON HWY JEFFERSON CITY, TN 37760

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 222 SS=D	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected	K 222	Life Care Center of Jefferson City is committed to upholding the highest standard of care for its residents. This includes substantial compliance with all applicable standards and regulatory requirements. The facility respectfully works in cooperation with the state of Tennessee Department of Health toward the best interest of those who require the services we provide. While this Plan of Correction is not to be considered an admission of validity of any findings, it is submitted in good faith as a required response to the survey conducted March 20th – 22th 2017. This Plan of Correction is the facility's allegation of substantial compliance with Federal and State requirements. **What corrective action will be accomplished for those residents found to have been affected by the deficit practice:** 1) All facility maintenance personnel were immediately in-serviced on NFPA 101 Life Safety Code Standard on 03/20/2017 by the Executive Director. a) Delayed egress door by laundry was fixed on 03/21/2017, door requires less than 15 pounds of pressure to operate the delayed egress system. **How you will identify other residents having the potential to be affected by the same deficit practice and what corrective action be taken:** 2) All facility residents and visitors have the potential to be affected. 100% audit completed by Maintenance Director of required inspections revealed no further areas of concern 03/21/2017	05/03/2017

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Juan P. Miranda — Executive Director — 04/05/17

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that e/ safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days owing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 /s following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued gram participation.

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K 222	Continued From page 1 throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is not met as evidenced by: Based on observation and testing, the facility failed to maintain all doors within the means of egress. NFPA 101 19.2.2.2.4, 7.2.1.6.1(3)(a) The deficiencies affect 1 of 7 smoke compartments. The census the day of the survey was 110 residents. The findings include: Observation and testing on 3/20/17 at 10:37 AM revealed the delayed egress door by laundry took more than 15 pounds of force to operate the delayed egress door by starting the delayed egress feature. The maintenance director and administrator were	K 222	What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur: 3) All facility maintenance personnel were immediately in-serviced on NFPA 101 Life Safety Code Standard on 03/20/2016 by the Executive Director. The maintenance director and/or the Maintenance Assistances will do audits to monitor compliance weekly for 4 weeks and monthly for 2 months. How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place: 4) a) Director of Maintenance will present results of audits to the Performance Improvement Committee 5)) The Performance Improvement Committee Consisting of Executive Director, Director of Nursing, Medical Director, Director of Rehabilitation, Director of Health Information Management, Dietary Manager, Director of Maintenance, Director of Environmental Services, Director of Social Services, Business office manager, Activities Director and Staff Development Coordinator will review the results/ If it is deemed necessary by the committee, additional education may be provided, the process evaluated/revised, and/or the audits reviewed for 3 months or until 100% compliance is achieved.	05/03/2017

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K 222	Continued From page 2 present during the deficiency identified and acknowledged by the administrator during the exit conference on 3/20/17.	K 222		
K 353 SS=E	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the automatic sprinkler system and its components. NFPA 101 2012 Ed. 19.3.5, 9.7, 9.7.5 NFPA 25 2011 Ed. 5.2.1.1.1* The deficiencies affect 3 of 7 smoke compartments. The census the day of the survey was 110 residents. The findings include:	K 353	What corrective action will be accomplished for those residents found to have been affected by the deficit practice: 1) All facility maintenance personnel were immediately in-serviced on NFPA 101 Life Safety Code Standard on 03/20/2017 by the Executive Director. a) All five corroded sprinkler heads were replaced on 03/28/2017. Insulation was immediately removed from 1 sprinkler head by room 208, all insulation in attic was checked and secured on 3/21/2017 How you will identify other residents having the potential to be affected by the same deficit practice and what corrective action be taken: 2) All facility residents and visitors have the potential to be affected. 100% audit completed by Maintenance Director of required inspections revealed no further areas of concern 03/21/2017 What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur: 3) All facility maintenance personnel were immediately in-serviced on NFPA 101 Life Safety Code Standard on 03/20/2016 by the Executive Director. The maintenance director and/or the Maintenance Assistances will do audits to monitor compliance weekly for 4 weeks and monthly for 2 months.	05/03/2017

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K 353	Continued From page 3 Observation on 3/20/17 between 11:15 PM and 1:40 PM revealed the following locations have corroded sprinkler heads an obstructed sprinkler heads: 1. 1 corroded sprinkler head in shower room at nurse's station 2. 2. 1 corroded sprinkler head outside under porch of the exit by room 123. 3. 1 corroded sprinkler head outside under the porch leading to the smoking area. 4. 2 of 2 corroded sprinkler heads in dish washing room in dietary. 5. 1 obstructed upright sprinkler head by insulation that has fallen down over top of the sprinkler head in the attic above by room 208. The maintenance director and administrator were present during the deficiency identified and acknowledged by the administrator during the exit conference on 3/20/17.	K 353	**How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place:** 4) a) Director of Maintenance will present results of audits to the Performance Improvement Committee 5)) The Performance Improvement Committee Consisting of Executive Director, Director of Nursing, Medical Director, Director of Rehabilitation, Director of Health Information Management, Dietary Manager, Director of Maintenance, Director of Environmental Services, Director of Social Services, Business office manager, Activities Director and Staff Development Coordinator will review the results/ If it is deemed necessary by the committee, additional education may be provided, the process evaluated/revised, and/or the audits reviewed for 3 months or until 100% compliance is achieved.	
K 711 SS=D	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This STANDARD is not met as evidenced by:	K 711	**How you will identify other residents having the potential to be affected by the same deficit practice and what corrective action be taken:** 2) All facility residents, associates and visitors have the potential to be affected. 100% of dietary personnel in-serviced no further areas of concern 03/24/2017 **What corrective action will be accomplished for those residents found to have been affected by the deficit practice:** 1) Dietary personnel were in-serviced on NFPA 101 Evacuation and relocation Standard on 03/20/2017, all dietary personnel were in-serviced by 03/24/2017 by the Executive Director, maintenance director and food services director.	05/03/2017

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K 711	Continued From page 4 Based on interview, the facility failed to train dietary staff to be familiar with fire procedures with cooking equipment located under the kitchen hood per the requirements of: NFPA 101 2012 Ed. 19.7.1.2 This deficiency affected 1 of 7 smoke compartments. The census the day of the survey was 110. The findings include: Interview with a dietary staff member on 3/20/17 at 1:08 PM revealed the 2 of 2 staff members in dietary department was not familiar with the correct order of use for the K type fire extinguisher and the ANSUL hood extinguishing system for an appliance fire in the kitchen. Staff members interviewed stated that they would use the K class fire extinguisher to extinguish a fire under the cooking hood. The ANSUL hood extinguishing system is required to be activated before the K class fire extinguisher per the signage placard above the extinguisher. The maintenance director and administrator were present during the deficiency identified and acknowledged by the administrator during the exit conference on 3/20/17.	K 711	a) All dietary personnel in-serviced on Evacuation and relocation standard; The ANSUL hood extinguisher system is required to be activated before the K class fire extinguisher per the signage placard above the extinguisher. **What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur:** 3) Dietary personnel were immediately in-serviced on NFPA 101 Evacuation and Relocation 03/20/2016 by the Executive Director, maintenance director and food services director. All dietary personnel were in-serviced by 03/24/2017. The food and services director and maintenance director will do audits to monitor compliance weekly for 4 weeks and monthly for 2 months. **How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place:** 4) Director of Maintenance/Food Services director will present results of audits to the Performance Improvement Committee 5)) The Performance Improvement Committee Consisting of Executive Director, Director of Nursing, Medical Director, Director of Rehabilitation, Director of Health Information Management, Dietary Manager, Director of Maintenance, Director of Environmental Services, Director of Social Services, Business office manager, Activities Director and Staff Development Coordinator will review the results/ If it is deemed necessary by the committee, additional education may be provided, the process evaluated/revised, and/or the audits reviewed for 3 months or until 100% compliance is achieved.	05/03/2017